Indiana Department of Insurance
Filing Company Checklist
INDIVIDUAL MEDICARE SUPPLEMENT Review Standards

(Checklist must be submitted with filing.)

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Statute/Regulation	*Requirement*	*N/A*	*Location in submitted documents*	*For IDOI USE ONLY* *Yes/No/Comments*
General Filing Requirements				
IC 27-1-3-15	***Filing Fee***—We will bill you quarterly for **each** form contained in the filing and for **each** company the form is filed for. The per form fee is $35 or the retaliatory fee based on your state of domicile. **PLEASE DO NOT** submit any filing fees with your filing.			
Bulletin 125	NAIC Standard A&H Transmittal Sheet— Use coding from NAIC Uniform Product Coding Matrix—Links to these items on the IDOI website or www.naic.org			
IC 27-1-26	Flesch readability certification			
Bulletin 125	A cover letter in duplicate and one copy of all forms to be filed. The cover letter should include:			
	a) A reference "Re:" line with the insurance company's name and NAIC number, and the form number of **each** form to be filed.			
	b) If there are numerous forms in one filing, please list them on a separate sheet of paper and indicate in the reference line "see attached list." Please list the most important form first and keep the same order in related correspondence			
	c) The name of a contact person, with telephone and fax numbers. **Please include an e-mail address so that we may correspond with you by e-mail.** On all correspondence, please include NAIC number and form number. Any submission of additional forms or materials should include a separate response letter, in duplicate, for each filing being addressed.			
Bulletin 125	A postage-paid, self-addressed envelope of adequate size to hold the "approved" or "filed" stamped duplicate correspondence and any extra copies of forms that you wish to have returned. (There is no need to send more than one copy of the forms.)			
Bulletin 125	If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, please pre-sort the materials, by company, before sending.			
Required Provisions for Medicare Supplement Policies	Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT			
IC 27-8-5-3(a)(1)	**ENTIRE CONTRACT: CHANGES**: This policy, including the endorsement and attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.			
IC 27-8-5-3(a)(2)	**TIME LIMIT ON CERTAIN DEFENSES:** After two (2) years from the date of issue of policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year			

	period.			

IC 27-8-5-3(a)(3)	**GRACE PERIOD:** A grace period of ("7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall remain in force.			
IC 27-8-5-3(a)(4)	**REINSTATEMENT:** If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy (see Code for remainder of language)			
IC 27-8-5-3(a)(5)	**NOTICE OF CLAIM:** Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer, or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. (See Code for alternative language for loss-of-time benefit policies.)			
IC 27-8-5-3(a)(6)	**CLAIM FORMS:** The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.			
IC 27-8-5-3(a)(7)	**PROOFS OF LOSS:** Written proof of loss must be furnished to the insurer at its office within 90 days after the date of such loss *(within 90 days after termination of insurer's liability period in case of policy providing periodic payments.)* Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year after the time proof is otherwise required.			
IC 27-8-5-3(a)(8) IC 27-8-5.7 "Clean Claims"	TIME OF PAYMENT OF CLAIMS: Payments under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss, or in accordance with IC 27-8-5.7, whichever is more favorable to the policyholder. (If policy provides for a periodic payment it will be paid not less frequently than monthly.) This provision must reflect compliance with IC 27-8-5.7.			
IC 27-8-5-3(a)(9)	**PAYMENT OF CLAIMS:** Indemnities will be payable to the insured.			
IC 27-8-5-3(a)(10)	**PHYSICAL EXAMINATIONS AND AUTOPSY:** The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.			
IC 27-8-5-3(a)(11)	**LEGAL ACTIONS:** No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.			
IC 27-8-5-3(a)(12)	**CHANGE OF BENEFICIARY:** Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary, or to any other change in this policy.			

IC 27-8-5-22	**REFUND OF PREMIUM AT DEATH:** Pro-rated from date following date of death to end of paid period.			

Optional Provisions for Individual Policies	The following provisions are not required in an individual policy. However, if a policy issued or delivered in Indiana addresses the matters listed below, its provisions must appear as stated, preceded by the captions or other approved captions. Any variance in this language must be at least as favorable to the insured and MUST be approved by the Department of Insurance.			
IC 27-8-5-3(b)(1)	**CHANGE OF OCCUPATION:** If the insured becomes injured or sick after changing to an occupation or engaging in work more hazardous than as stated in the policy, the insurer will pay only such benefits as the premium paid would have purchased. If the insured changes to an occupation less hazardous, then upon receipt of proof, the insurer will reduce the premium rate accordingly and will return the excess pro rata unearned premium. In applying this policy, the insurer must use the classification of risk and the premium rates last filed with the Department.			
IC 27-8-5-3(b)(2)	**MISSTATEMENT OF AGE:** If the age of the insured has been misstated, the amounts payable shall be such as the premium paid would have purchased at the correct age.			
IC 27-8-5-3(b)(3)	**OTHER INSURANCE WITH THIS INSURER:** If the insured currently has more than one policy with this insurer, with total benefits exceeding the maximum limit of the policy, then the excess insurance is void and the premium for the excess insurance shall be returned. (Alternatively, only one policy elected by the insured shall be effective, and the insurer will return any premium for other policies.)			
IC 27-8-5-3(b)(4) / IC 27-8-5-3(b)(5)	**INSURANCE WITH OTHER INSURER(S)**. If there is other valid coverage for the same loss, on a provision of service basis or on an expense incurred basis, and this insurer has not been given notice of the other coverage prior to the loss, the liability of this insurer will be adjusted as well as a portion of the premiums paid.			
IC 27-8-5-3(b)(6)	**RELATION OF EARNINGS TO INSURANCE:** If total loss of time benefits promised under all valid loss of time coverage exceeds monthly earnings of the insured at time of disability or earning for the period of 2 years immediately preceding a disability, whichever is greater, the insurer will be liable only for such proportionate amount of benefits, but this amount cannot be below $200 or the sum specified in such coverage. (See Code for optional language if policy provides benefits until 50 years of age or if issued after 44 years of age for at least five (5) years.)			
IC 27-8-5-3(b)(7)	**UNPAID PREMIUM:** Any premium due and unpaid upon the payment of a claim under the policy may be deducted from the claim.			
IC 27-8-5-3(b)(8)	**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, conflicts with the statutes of the state where the insured resides on such date is amended to conform to the minimum requirements of such statutes.			
IC 27-8-5-3(b)(9)	**ILLEGAL OCCUPATION:** Insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which the contributing cause was the insured's being engaged in an illegal occupation.			
IC 27-8-5-3(b)(10)	**INTOXICANTS AND NARCOTICS:** Insurer shall not be liable for a loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of narcotics unless taken on the advice of a physician. **(Note: to be excluded, the loss must be in consequence of the insured's being intoxicated, not just occurring while the insured is intoxicated or under the influence of narcotics.)**			
REQUIRED MEDICARE SUPPLEMENT PROVISIONS				
IC 27-8-13-9	**DUPLICATE BENEFITS**: A Medicare Supplement policy, contract, or certificate may not contain benefits that			

	duplicate benefits provided by Medicare. A *change* in Medicare coverage that becomes effective after a Medicare Supplement policy, contract, or certificate is in force and that causes a duplication of benefits does not void the policy, contract, or certificate.			
IC 27-8-13-17	**RETURN PRIVILEGE**: Medicare Supplement policies and certificates must have a notice prominently printed on the first page (or attached to the first page) stating the applicant has the right to return the policy or certificate within 30 days of delivery and to have premium refunded if applicant is not satisfied.			
760 IAC 3-2-6 760 IAC 3-3-1	**DEFINITIONS**: No policy or certificate may be advertised, solicited, or issued for delivery as a Medicare Supplement policy or certificate unless the definition of Medicare is included in the policy or certificate. Medicare defined is the "Health Insurance for the Aged Act." Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended."			
760 IAC 3-5-1(b)(1) 760 IAC 3-6-1(b)	**PRE-EXISTING CONDITION**: A Medicare Supplement policy or certificate shall not a) exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a pre-existing condition or b) define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.			
760 IAC 3-9-1	**OPEN ENROLLMENT:** Issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate or discriminate the pricing of the policy or certificate because of health status, claims experience, receipt of health care, or medical condition of applicant submitting before or during the six (6) month period when individual is both 65 or older and enrolled under Medicare Part B. All plans currently available will be made available to those who qualify regardless of age.			
760 IAC 3-11-1	**LOSS RATIO STANDARDS & REFUND OF PREMIUM:** a) Policy form or certificate form is expected to return at least 75% of the aggregate amount of premiums earned. b) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level.			
760 IAC 3-13-1	**COMMISSION**: a) May be provided to an agent or other representative only if the first year commission is no more than 200% of the commission paid for selling or servicing the policy or certificate in the second year. b) Commission paid in renewal years must be the same as commission in the 2nd year and must be paid for no fewer than 5 renewal years.			
760 IAC 3-14-1	**REQUIRED DISCLOSURES**: Language or specifications shall be consistent with the type of contract issued. The provision shall a) be appropriately captioned b) appear on the first page of the policy and c) include any reservation by the issuer of the right to change premiums and include automatic renewal premium increases based on the policyholder's age.			
760 IAC 3-15-1	**APPLICATION FORMS / REPLACEMENT COVERAGE**: a) Shall include statements and questions designed to elicit information as to whether the applicant has another Medicare Supplement, Medicare Advantage, or Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate currently in force. b) Replacement of Medicare Supplement coverage requires a notice be provided in similar form to "NOTICE OF APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE. SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE."			
Bulletin 128	**FILING COMPLAINTS WITH THE DOI**: Notice to policyholders regarding filing complaints with the Department of Insurance			
MEDICARE SUPPLEMENT Plans				

Plan A 760 IAC 3-6-1	-Core benefits included in all plans and pays 1) Part A Hospital co-payment for 61-90 days and another co-payment for 91-150 days 2) Additional 365 days of hospitalization after Medicare benefits end 3) Part B co-payment, usually 20% of Medicare approved amount 4) First three pints of blood per year.			
Plan B 760 IAC 3-6-1	-Core benefits -Part A Deductible (inpatient hospital deductible)			
Plan C 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment : for days 21-100 in SNF -Part A Deductible -Part B Deductible (for physical or other OP services) -Foreign Travel Emergency (Medicare does not pay for care received in a foreign country.) MS covers, after a $250 deductible, 80% of health expenses for emergency care received n the first 60 days to a lifetime max of 50k			
Plan D 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Foreign Travel Emergency -At-home Recovery (Medicare only pays for skilled nursing home health care.) MS covers home health visits for help with daily living when Medicare is received or within 8 weeks from the last Medicare visit			
Plan E 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Foreign Travel Emergency -Preventive Care not covered by Medicare: covers annual preventive exam and services to an annual max			
Plan F 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-payment -Part A Deductible -Part B Deductible -Part B excess (80%):Medicare does not pay excess charges above its approved amount.. Part B Excess covers the difference between the Medicare approved amount and the limiting charge (no more than 15% above Medicare approved amount). Pays either 80% or 100% of Part B excess charges -Foreign Travel Emergency			
Plan G 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-insurance -Part A Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery			
Plan H 760 IAC 3-6-1	-Core benefit -Skilled Nursing Co-insurance -Part A Deductible -Foreign Travel Emergency			
Plan I 760 IAC 3-6-1	-Core Benefit -Skilled Nursing Co-insurance -Part A Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery			
Plan J 760 IAC 3-6-1	-Core benefits -Skilled Nursing Co-insurance -Part A Deductible -Part B Deductible -Part B excess (100%) -Foreign Travel Emergency -At-home Recovery -Preventive care not covered by Medicare			
Plan K 760 IAC 3-6-1	-Core benefits: 1)100% of Part A co-insurance plus 365 days after Medicare benefits end 2) 50% hospice cost-sharing 3)50% of Medicare-eligible expenses for 1st 3 pints of blood 4)50% Part B co-insurance except 100% for Part B preventive services -50% Skilled Nursing Co-insurance -50% Part A Deductible -Out-of-Pocket annual limit :increases each year w/inflation			
Plan L 760 IAC 3-6-1	-Core benefits: 1)100%of Part A co-insurance plus 365 days after Medicare benefits end 2)75% hospice cost-			

	sharing 3)75% of Medicare-eligible expenses for 1st 3 pints of blood 4)75% Part B co-insurance except 100% for Part B preventive services -75% Skilled Nursing Co-insurance -75% Part A Deductible -Out-of-Pocket annual limit :increases each year w/inflation			
760 IAC 3-8-1	**MEDICARE SELECT**: 1) A Medicare Select issuer shall not issue a policy or certificate until its plan of operation has been approved by the commissioner; 2) Disclosure; 3) Written grievance procedures for hearing complaints and resolving written grievances shall be used.			
General Regulatory Issues	Under the authority provided by IC 27-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.			
Application questions 27-8-5-1(d)(2) 27-8-5-1.5(l)	1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.			
Arbitration 27-8-5-1(d)(2)	Mandatory and/or binding arbitration provisions are prohibited.			
First manifest language 27-8-5-19(c)(6) 27-8-5-2.5 27-8-15-27	Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.			
Foreign language forms Bulletin 106	Foreign language forms must comply with Bulletin 106.			
Large endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.			
Open endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.			
Privacy of health information 27-8-5-1(d)(2) 27-8-5-1.5(l)	Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.			
Various fees 27-8-5-1(d)(2) 27-8-5-1.5(l)	Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.			
Bulletin 103	No full and final discretion clauses except where policy is governed by ERISA			
760 IAC 1-8	Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading			
27-8-5-1(d)(2) 27-8-5-1.5(l)	The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.			

I hereby certify, pursuant to IC 27-8-5-1.5(i)(1)(C), that the policy form submitted with this checklist meets all requirements of Indiana law.

Filer: _____

Printed: _____

Company: _____

Title: _____

Date: _____